



March 27, 2007

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## ENGROSSED SENATE BILL No. 566

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DIGEST OF SB 566 (Updated March 22, 2007 6:40 pm - DI 77)

**Citations Affected:** IC 12-15; IC 12-19.

**Synopsis:** Medicaid claims and alternative psychiatric facility settings. Prohibits the office of Medicaid policy and planning (OMPP) or a contractor of OMPP from reducing Medicaid providers reimbursement rates if OMPP has reverted appropriated money to the state general fund during the previous state fiscal year. Requires OMPP to accept a Medicaid claim for services provided a Medicaid recipient for three years after the date the service was provided. Specifies the circumstances in which a Medicaid claim may not be denied by a Medicaid provider. Requires OMPP to pay certain Medicaid claims at a rate equal to the highest rate of the state employee health plan. Requires an insurer to accept a Medicaid claim for services provided a Medicaid recipient for three years after the date the service was provided. Specifies the circumstances in which a Medicaid claim may not be denied by an insurer. States that notice requirements may be satisfied by electronic or mail submission (current law provides only for certified or registered mail). Requires an insurer to accept the state's right of recovery and assignment of certain rights as required by federal law. Adds certain less restrictive settings to the definition of children's psychiatric residential treatment services.

**Effective:** July 1, 2007.

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### Dillon

(HOUSE SPONSORS — BROWN C, BROWN T)

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January 23, 2007, read first time and referred to Committee on Health and Provider Services.

February 8, 2007, amended, reported favorably — Do Pass.

February 12, 2007, read second time, ordered engrossed.

February 13, 2007, engrossed. Read third time, passed. Yeas 46, nays 0.

#### HOUSE ACTION

March 6, 2007, read first time and referred to Committee on Public Health.

March 26, 2007, amended, reported — Do Pass. Recommended to Committee on Ways and Means.

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ES 566—LS 7409/DI 104+



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March 27, 2007

First Regular Session 115th General Assembly (2007)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2006 Regular Session of the General Assembly.

## ENGROSSED SENATE BILL No. 566

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

*Be it enacted by the General Assembly of the State of Indiana:*

- 1 SECTION 1. IC 12-15-13-4 IS ADDED TO THE INDIANA CODE  
2 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
3 1, 2007]: **Sec. 4. The office or a contractor of the office may not,**  
4 **during a state biennial budget period, reduce the rate of**  
5 **reimbursement to a Medicaid provider for a service that is**  
6 **reimbursable under the Medicaid program if the office has**  
7 **reverted to the state general fund any money appropriated to the**  
8 **office for the Medicaid program during the previous state fiscal**  
9 **year.**
- 10 SECTION 2. IC 12-15-13-5 IS ADDED TO THE INDIANA CODE  
11 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
12 1, 2007]: **Sec. 5. (a) Notwithstanding any other law, the office or a**  
13 **contractor of the office shall accept a Medicaid claim for a**  
14 **Medicaid recipient, including a Medicaid waiver recipient, for a**  
15 **service that is reimbursable under the Medicaid program for the**  
16 **Medicaid recipient for three (3) years after the date the service was**  
17 **provided.**

ES 566—LS 7409/DI 104+



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(b) The office or a contractor of the office may not deny a Medicaid claim submitted by the office solely on the basis of:

- (1) the date of submission of the claim;
- (2) the type or format of the claim form; or
- (3) a failure to provide proper documentation at the point of sale that is the basis of the claim;

if the claim is submitted by the Medicaid provider within three (3) years after the date the service was provided as required in subsection (a).

(c) The office or a contractor of the office shall pay a Medicaid claim submitted under this section at a rate equal to the highest rate of a state employee health plan, as defined in IC 5-10-8-6.6.

SECTION 3. IC 12-15-29-4.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4.5. (a) An insurer shall accept a Medicaid claim for a Medicaid recipient for three (3) years from the date the service was provided.

(b) An insurer may not deny a Medicaid claim submitted by the office solely on the basis of:

- (1) the date of submission of the claim;
- (2) the type or format of the claim form; or
- (3) a failure to provide proper documentation at the point of sale that is the basis of the claim;

if the claim is submitted by the office within three (3) years from the date the service was provided as required in subsection (a) and the office commences action to enforce the office's rights regarding the claim within six (6) years of the office's submission of the claim.

(c) An insurer may not deny a Medicaid claim submitted by the office solely due to a lack of prior authorization. An insurer shall conduct the prior authorization on a retrospective basis for claims where prior authorization is necessary and adjudicate any claim authorized in this manner as if the claim received prior authorization.

SECTION 4. IC 12-15-29-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 7. (a) The notice requirements of section 4 of this chapter are satisfied if:

- (1) the insurer receives from the office, ~~by certified electronically~~ or ~~registered by United States~~ mail, a statement of the claims paid or medical services rendered by the office, together with a claim for reimbursement; or
- (2) the insurer receives a claim from a beneficiary stating that the beneficiary has applied for or has received Medicaid from the

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office in connection with the same claim.

(b) An insurer that receives a claim under subsection (a)(2) shall notify the office of the insurer's obligation on the claim and shall:

(1) pay the obligation to the provider of service; or

(2) if the office has provided Medicaid, pay the office.

SECTION 5. IC 12-15-29-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) IC 27-8-23 applies to this section.

(b) To the extent that payment for covered medical expenses has been made under the state Medicaid program for health care items or services furnished to a person, in a case where a third party has a legal liability to make payments, the state is considered to have acquired the rights of the person to payment by any other party for the health care items or services.

**(c) As required under 42 U.S.C. 1396a(a)(25), an insurer shall accept the state's right of recovery and the assignment to the state of any right of the individual or entity to payment for a health care item or service for which payment has been made under the state Medicaid plan.**

SECTION 6. IC 12-19-7.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. As used in this chapter, "children's psychiatric residential treatment services" means services that are:

(1) eligible for federal financial participation under the state Medicaid plan; and

(2) provided to individuals less than twenty-one (21) years of age who are:

(A) eligible for services under the state Medicaid plan;

(B) approved by the office **as eligible** for admission to and treatment in a private psychiatric residential treatment facility; and

(C) **either** residing in a:

(i) private psychiatric residential facility for the purposes of treatment for a mental health condition, based on an approved treatment plan that complies with applicable federal and state Medicaid rules and regulations; **or**

(ii) **less restrictive setting and participating in a federally approved community alternatives to psychiatric residential treatment facilities demonstration grant that provides safe, intensive, and appropriate services under an approved treatment plan that complies with federal and state Medicaid law.**

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## COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 566, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 2, delete lines 33 through 42, begin a new paragraph and insert:

"SECTION 4. IC 12-19-7.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. As used in this chapter, "children's psychiatric residential treatment services" means services that are:

- (1) eligible for federal financial participation under the state Medicaid plan; and
- (2) provided to individuals less than twenty-one (21) years of age who are:

- (A) eligible for services under the state Medicaid plan;
- (B) approved by the office for admission to and treatment in:
  - (i) a private psychiatric residential treatment facility; ~~and~~ **or**
  - (ii) **another level of care setting; and**
- (C) residing in:
  - (i) a private psychiatric residential facility; **or**
  - (ii) **an alternative setting;**

for the purposes of treatment for a mental health condition, based on an approved treatment plan that complies with applicable federal and state Medicaid rules and regulations.".

Delete page 3.

and when so amended that said bill do pass.

(Reference is to SB 566 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 0.

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## COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 566, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-15-13-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 4. The office or a contractor of the office may not, during a state biennial budget period, reduce the rate of reimbursement to a Medicaid provider for a service that is reimbursable under the Medicaid program if the office has reverted to the state general fund any money appropriated to the office for the Medicaid program during the previous state fiscal year.**

SECTION 2. IC 12-15-13-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 5. (a) Notwithstanding any other law, the office or a contractor of the office shall accept a Medicaid claim for a Medicaid recipient, including a Medicaid waiver recipient, for a service that is reimbursable under the Medicaid program for the Medicaid recipient for three (3) years after the date the service was provided.**

**(b) The office or a contractor of the office may not deny a Medicaid claim submitted by the office solely on the basis of:**

- (1) the date of submission of the claim;**
- (2) the type or format of the claim form; or**
- (3) a failure to provide proper documentation at the point of sale that is the basis of the claim;**

**if the claim is submitted by the Medicaid provider within three (3) years after the date the service was provided as required in subsection (a).**

**(c) The office or a contractor of the office shall pay a Medicaid claim submitted under this section at a rate equal to the highest rate of a state employee health plan, as defined in IC 5-10-8-6.6."**

Page 1, line 4, before "(3)" insert "**three**".

Page 1, line 11, delete "point-of-sale" and insert "**point of sale**".

Page 2, delete lines 33 through 42, begin a new paragraph and insert:

"SECTION 6. IC 12-19-7.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 1. As used in this**

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chapter, "children's psychiatric residential treatment services" means services that are:

- (1) eligible for federal financial participation under the state Medicaid plan; and
- (2) provided to individuals less than twenty-one (21) years of age who are:
  - (A) eligible for services under the state Medicaid plan;
  - (B) approved by the office **as eligible** for admission to and treatment in a private psychiatric residential treatment facility; and
  - (C) **either** residing in a:
    - (i) private psychiatric residential facility for the purposes of treatment for a mental health condition, based on an approved treatment plan that complies with applicable federal and state Medicaid rules and regulations; **or**
    - (ii) **less restrictive setting and participating in a federally approved community alternatives to psychiatric residential treatment facilities demonstration grant that provides safe, intensive, and appropriate services under an approved treatment plan that complies with federal and state Medicaid law."**

Delete page 3.

Re-number all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 566 as printed February 9, 2007.)

BROWN C, Chair

Committee Vote: yeas 8, nays 3.

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